UTAH CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

ANNUAL REPORT

Federal Fiscal Year 2005

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **UT**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature: **Nathan Checketts**

SCHIP Program Name(s): **Children's Health Insurance Program**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☒ Separate Child Health Program Only
- ☐ Combination of the above

Reporting Period: **2005** *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

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Submission Date: **1/24/2006**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	0	% of FPL conception to birth	200	% of FPL
	From		% of FPL for **infants**		% of FPL	From	0	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	From	0	% of FPL for 1 **through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	From	0	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	From	0	% of FPL for children ages **17 and 18**	200	% of FPL

Is presumptive eligibility provided for children?	☐	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☐	No
	☐	Yes, for whom and how long?	☒	Yes, for whom and how long? For all eligible enrollees, a 4 day grace period is allowed when an emergency or some other circumstance beyond the control of the applicant prevents them from applying for CHIP. The eligibility date must be within an open enrollment period, and the applicant must ask for the coverage at the time of application.
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	No
		☐	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No	☐	No
	☐	Yes – please check all that apply	☒	Yes – please check all that apply
	☐	Signature page must be printed and mailed in	☐	Signature page must be printed and mailed in
	☐	Family documentation must be mailed (i.e., income documentation)	☒	Family documentation must be mailed (i.e., income documentation)
	☐	Electronic signature is required	☒	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☐	No	☒	No
	☐	Yes	☐	Yes
	Specify number of months		Specify number of months	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
			There are three instances when a child would lose eligibility during the 12 month enrollment period: (1) an enrollee becomes enrolled in other private or employer-sponsored health insurance. (2)the family does not pay their quarterly CHIP premium. (3)a child becomes enrolled in Medicaid.	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☐	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	0
	Premium amount		Premium amount	25
	Yearly cap		Yearly cap	5% of the yearly income
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Native Americans and enrollees 100% FPL or below are exempt from paying premiums. Enrollees 101% to 150% FPL pay $13 per family, per quarter. Enrollees 151% to 200% FPL pay $25 per family per quarter. The yearly cap on all cost sharing (including premiums and copays) is 5% of the family's yearly gross countable income.	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☐	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	X	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☐	No	☐	No
	☐	Yes, we send out form to family with their information pre-completed and	☒	Yes, we send out form to family with their information pre-completed and
		☐ We send out form to family with their information pre-completed and ask for confirmation		☐ We send out form to family with their information pre-completed and ask for confirmation
		☐ We send out form but do not require a response unless income or other circumstances have changed		☒ We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Comments on Responses in Table:

At application and renewal, verification of income is required. If questionable, verification of citizenship is required. If a child is a qualified alien, verification of their alien registration number is required. If needed, this documentation is requested when the eligibility worker receives the application. It is not required to begin the application process.

When health insurance has been voluntarily terminated, a child is not eligible for CHIP enrollment until 90 days after the health insurance was terminated.

Utah CHIP utilizes both methods of renewal depending upon the family's circumstances. Section III, Eligibility Redetermination and Retention gives a complete summary of Utah's process.

2. Is there an assets test for children in your Medicaid program? ☒ Yes ☐ No ☐ N/A

3. Is it different from the assets test in your separate child health program? ☐ Yes ☐ No ☒ N/A

4. Are there income disregards for your Medicaid program? ☒ Yes ☐ No ☐ N/A

5. Are they different from the income disregards in your separate child health program? ☐ Yes ☐ No ☒ N/A

6. Is a joint application used for your Medicaid and separate child health program? ☐ Yes ☒ No ☐ N/A

Comments: Although Utah CHIP has a separate application form, applicants for CHIP may apply using a CHIP application form or a Medicaid form.

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☐	☐	☐	☒	☐
b) Application	☐	☐	☐	☐	☒	☐
c) Benefit structure	☐	☐	☐	☐	☒	☐
d) Cost sharing (including amounts, populations, & collection process)	☐	☐	☐	☐	☒	☐
e) Crowd out policies	☐	☐	☐	☐	☒	☐
f) Delivery system	☐	☐	☐	☐	☒	☐
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☐	☐	☒	☐	☐
h) Eligibility levels / target population	☐	☐	☐	☐	☒	☐
i) Assets test in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
j) Income disregards in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
k) Eligibility redetermination process	☐	☐	☐	☐	☒	☐
l) Enrollment process for health plan selection	☐	☐	☐	☐	☒	☐
m) Family coverage	☐	☐	☐	☐	☒	☐
n) Outreach (e.g., decrease funds, target outreach)	☐	☐	☐	☐	☒	☐
o) Premium assistance	☐	☐	☐	☐	☒	☐
p) Prenatal Eligibility expansion	☐	☐	☐	☐	☒	☐
q) Waiver populations (funded under title XXI)						
Parents	☐	☐	☐	☐	☒	☐
Pregnant women	☐	☐	☐	☐	☒	☐
Childless adults	☐	☐	☐	☐	☒	☐

r) Other – please specify

a. _____	☐	☐	☐		☐	☒	☐	
b. _____	☐	☐	☐		☐	☒	☐	
c. _____	☐	☐	☐		☐	☒	☐	

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	In July, 2005, the Utah State Legislature increased state funding to allow CHIP to cover a monthly average of 40,000 children. Enrollment for CHIP has been open since July 1, 2005 and will continue to be open until we reach the 40,000 cap.
h) Eligibility levels / target population	
i) Assets test in Medicaid and/or SCHIP	
j) Income disregards in Medicaid and/or SCHIP	
k) Eligibility redetermination process	
l) Enrollment process for health plan selection	

m) Family coverage	
n) Outreach	
o) Premium assistance	
p) Prenatal Eligibility Expansion	

q) Waiver populations (funded under title XXI)

Parents	
Pregnant women	
Childless adults	

r) Other – please specify

a.	
b.	
c.	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or

HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2005	Data Source(s): HEDIS data for measurement year 2004 Definition of Population Included in Measure: CHIP enrollees who had 5 or more well-child visits with a primary care practitioner in the first 15 months of life. Baseline / Year: (Specify numerator and denominator for rates) Statistical rates were calculated by dividing the number of CHIP enrollees who saw a primary care practitioner by the total number of CHIP enrollees. Performance Progress/Year: (Specify numerator and denominator for rates) 65.4% of CHIP enrolled children who turned 15 months old during 2004 and had been continuously enrolled from 31 days of age, received at least 5 well child visits with a primary care provider during their first 15 months of life. Explanation of Progress: In 2003, the percentage of children who had five or more well child visits in the first 15 months of life was 50.5%. In 2004, the percentage increased to 65.4%, which shows a 14.9% increase. Other Comments on Measure:

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2005	Data Source(s): HEDIS data for measurement year 2004 Definition of Population Included in Measure: CHIP enrollees ages 3-6 who had one or more well-child visits with a primary care practitioner in 2004. Baseline / Year: (Specify numerator and denominator for rates) Statistical rates were calculated by dividing the number of CHIP enrollees ages 3-6 who saw a primary care practitioner for a well-child visit in 2004 by the total number of CHIP enrollees ages 3-6. Performance Progress/Year: (Specify numerator and denominator for rates) 39.2% of the CHIP enrolles ages 3-6 had one or more well child visits with a primary care practioner in 2004. Explanation of Progress: In 2003, the percentage of CHIP enrollees ages 3-6 who had one or more well child visits with a primary care practitioner was 39.1%. In 2004, the percentage increased to 39.2%, which shows a .1% increase. Other Comments on Measure:
Use of appropriate medications for children with asthma Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☒ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

Measure	Measurement Specification	Performance Measures and Progress
Children's access to primary care practitioners Not Reported Because: ☐ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*. HEDIS 2005	Data Source(s): HEDIS, 2005 Definition of Population Included in Measure: CHIP enrollees ages 1-11 who had one or more visits with a primary care practitioner in 2004. Baseline / Year: (Specify numerator and denominator for rates) Statistical rates were calculated by dividing the number of CHIP enrollees ages 1-11 who had a visit with a primary care practitioner in 2004 by the total number of CHIP enrollees ages 1-11. Performance Progress/Year: (Specify numerator and denominator for rates) 84.5% of CHIP enrollees ages 1-11 had a visit with a primary care practitioner in 2004. Explanation of Progress: In 2003, the percentage of CHIP enrollees ages 1-11 who had a visit with a primary care practitioner was 88.7%. In 2004, the percentage decreased to 84.5%, which shows a 4.2% decrease. Other Comments on Measure: Although the percentage decreased, it is still above the national average for Medicaid of 83.7%
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: ☒ Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress:

Measure	Measurement Specification	Performance Measures and Progress
Adult access to preventive/ambulatory health services Not Reported Because: X Population not covered. ☐ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure
Adult Prenatal and postpartum care (prenatal visits): ☐ **Coverage for pregnant women over age 19 through a demonstration** ☐ **Coverage for unborn children through the SCHIP state plan** ☒ **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: ☐ Population not covered. ☒ Data not available. *Explain*. ☐ Not able to report due to small sample size (less than 30.) *Specify sample size.* ☐ Other. *Explain*. Even though Utah CHIP covers prenatal and postpartum care for enrollees ages 0-18, data for this measure has not been reported. We plan on requesting the data for the next reporting period.	☐ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified. Specify version of HEDIS used.* ☐ Other. *Explain*.	Data Source(s): NA Definition of Population Included in Measure: NA Baseline / Year: (Specify numerator and denominator for rates) NA Performance Progress/Year: (Specify numerator and denominator for rates) NA Explanation of Progress: NA Other Comments on Measure: NA

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program	0	0	
Separate Child Health Program	38,693	43,931	13

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

      In January, 2005 an open enrollment period was held. In addition, Utah CHIP received additional state funding allowing us to increase our CHIP cap from 28,000 children to 40,000 children, so we started another open enrollment period in July, 2005 which is still ongoing.

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2005 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	50	9.6	7.0	1.3
1998-2000	44	9.0	5.9	1.2
2000-2002	46	7.7	5.9	1.0
2002-2004	47	7.8	5.9	0.9
Percent change 1996-1998 vs. 2002-2004	(6.0)%	NA	(15.7)%	NA

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

NA

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	2003-2004 Utah Health Status Survey
Reporting period (2 or more points in time)	2003 - 2004
Methodology	2004 Utah Health Status Survey is a complex survey sample designed to be representative of all Utahns. It is a weighted probability sample of 6,056 households disproportionately stratified by 12 local health districts that cover the entire state.
Population	Children age 0-18 in a sample size of 6,056 households
Sample sizes	809,865 children age 0-18.
Number and/or rate for two or more points in time	For children age 0-18, the uninsured rate for 2003 was 7.2%. The uninsured rate for 2004 was 8.3%.
Statistical significance of results	Between 2003 and 2004, for children age 0-18, the uninsured rate showed a significant increase of 1.1%. For children from families who met income criteria for CHIP, there was a decrease of .3%.

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

Comparability with other surveys is an issue with all surveys. Differences in survey design, survey questions, estimation procedures, the socio-demographic and economic context, and changes in the structure and financing of the health care delivery system may all affect comparison between the 2003-2004 Utah Health Status Survey and other surveys, including those conducted by the U.S. Bureau of the Census. The 2003-2004 Utah Health Status Survey was based on the 2001 and 1996 Utah Health Status Survey questionnaires. For the 2003-2004 questionaire, some changes were made in order to obtain more detailed information and to allow for comparison with large federal surveys, such as the Current Population Survey (CPS).

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

Estimates developed from the sample may differ from results of a complete census of all households in Utah due to sampling and non-sampling errors. Each type of error is present in estimates based on a survey sample. Sampling error refers to random variation that occurs because only a subset of the entire population is sampled and used to estimate the finding in the entire population. Sampling error has been expressed in the 2003-2004 Utah Health Status Survey as a 95% confidence interval. No specific efforts were made to quantify the magnitude of non-sampling error. Non-sampling error was minimized by good questionnaire design, use of standardization in interviewer behavior and frequent, on-site, interviewer monitoring and supervision.

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question.)***

   Utah CHIP does not collect nor measure Medicaid data. However, during open enrollment periods approximately 15% of all CHIP denials were because the children were approved for Medicaid.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives Related to Reducing the Number of Uninsured Children *(Mandatory for all states for each reporting year)* ***(This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)***		
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: The percentage of Utah children from birth to 19 years of age without health insurance will be decreased to 6%.	Data Source(s): 2003-2004 Utah Health Status Survey Definition of Population Included in Measure: Utah children from birth to age 18 who live in Utah and those who lack health insurance. Methodology: Complex survey sample Baseline / Year: (Specify numerator and denominator for rates) Data from the 2004 Utah Health Status Survey was compared to the 2003 Health Status Survey. Performance Progress / Year: (Specify numerator and denominator for rates) Between 2003 and 2004 for Utah children ages 0-18, there was an increase of 1.1% in the overall uninsured rate, and a slight decrease of .3% for children from families who met the income criteria for CHIP. Statistical rates for both the 2003 and 2004 Utah Health Status Surveys were calculated by dividing the number of Utah children ages 0-18 who lacked health insurance by the total number of Utah children ages 0-18. Explanation of Progress: For children age 0-18, the uninsured rate showed a significant increase (8.3% in 2004) from the 2003 rate (7.2%). For children from families who met income criteria for CHIP, there was a small decrease of .3% Other Comments on Measure:

Objectives Related to SCHIP Enrollment		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: By December 2006, at least 40,000 previously uninsured CHIP eligible children will be enrolled in the Utah CHIP program.	Data Source(s): State Eligibility System (PACMIS) Definition of Population Included in Measure: Number of children enrolled in Utah CHIP. Methodology: Data from PACMIS Baseline / Year: (Specify numerator and denominator for rates) Utah CHIP was implemented in July, 1998. Performance Progress / Year: (Specify numerator and denominator for rates) At the end of FFY 2005, 32,629 children were enrolled in CHIP. Explanation of Progress: Prior to July, 2005, state funding allowed Utah CHIP to enroll and maintain a monthly average of 28,000 children. In July, 2005 state funds were increased to allow CHIP to insure an average of 40,000 children. Between Jun 2005 and the end of FFY 2005, 4,361 additional children have been enrolled. Other Comments on Measure: At the end of FFY 2005, 93,766 children were ever enrolled in CHIP (unduplicated count.)

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)

☒ New/revised
☐ Continuing
☐ Discontinued

Explain:

Goal #1:

☒ HEDIS.
Specify version of HEDIS used.

☐ HEDIS-Like.
Explain how HEDIS was modified.
Specify version of HEDIS used.

☐ Other. *Explain*.

By December, 2006, the percentage of children enrolled in Utah CHIP who have had a visit with a primary care practitioner in the previous year will increase from 88.7 to 90%.

Data Source(s):
HEDIS, 2005

Definition of Population Included in Measure:
CHIP enrollees ages 1-11 who had one or more visits with a primary care practitioner in 2004.

Methodology:
2005 HEDIS measurements which are a core subset of the full HEDIS dataset reported by Utah HMO's . Measures are based on information from patient visits in 2004.

Baseline / Year:
(Specify numerator and denominator for rates)
Statistical rates were calculated by dividing the number of CHIP enrollees ages 1-11 who had a visit with a primary care practitioner in 2004 by the total number of CHIP enrollees ages 1-11.

Performance Progress / Year:
(Specify numerator and denominator for rates)
84.5% of CHIP enrollees ages 1-11 had a visit with a primary care practitioner in 2004.

Explanation of Progress:
In 2003, the percentage of CHIP enrollees ages 1-11 who had a visit with a primary care practitioner was 88.7%. In 2004, the percentage decreased to 84.5%, which shows a 4.2% decrease.

Other Comments on Measure:
NA

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

☐ New/revised ☒ Continuing ☐ Discontinued Explain:	Goal #1: ☒ HEDIS. *Specify version of HEDIS used.* ☐ HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* ☐ Other. *Explain*. Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	Data Source(s): HEDIS 2005 Definition of Population Included in Measure: CHIP enrollees ages 0-5 who had 5 or more well-child visits with a primary care practitioner in 2004; CHIP enrollees ages 3-6 who had one or more well-child visits with a primary care practitioner in 2004; and CHIP enrollees ages 12-18 who had a least one well-care visit with a primary care provider in 2004. Methodology: 2005 HEDIS measurements which are a core subset of the full HEDIS dataset reported by Utah HMO's . Measures are based on information from patient visits in 2004. Baseline / Year: (Specify numerator and denominator for rates) Statistical rates were calculated by dividing the number of CHIP enrollees in each age group who saw a primary care practitioner by the total number of CHIP enrollees in each age group. Performance Progress / Year: (Specify numerator and denominator for rates) 65.4% of CHIP enrolled children who turned 15 months old during 2004 received at least 5 well child visits with a primary care provider; 39.1% of CHIP enrollees ages 3-6 had one or more well child visits with a primary care practitioner in 2004; and 19.4% of CHIP enrollees ages 12-18 had at least one well-care visit with a primary care provider in 2004. Explanation of Progress: In 2003, the percentage of children who had five or more well child visits in the first 15 months of life was 50.5%. In 2004, the percentage increased to 65.4%, which shows a 14.9% increase. In 2003, the percentage of CHIP enrollees ages 3-6 who had one or more well child visits with a primary care practitioner was 39.1%. In 2004, the percentage increased to 39.2%, which shows a .1% increase. In 2003, the percentage of CHIP enrollees ages 12-18 who had at least one well-care visit with a primary care practitioner was 16.4. In 2004 it increased to 19.4, which shows a 3% increase. Other Comments on Measure:

2. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

The CHIP program participates in the Consumer Assessment of Health Plans Survey (CAHPS)every other year. This survey measures both access to and qualify of care received by the Utah CHIP population. Based upon the most recent survey (2004), both CHIP plans are well above national benchmarks in nearly all consumer satisfaction measures.

3. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

Beginning in 2005, Utah CHIP will start participating in the annual Utah CAHPS Survey every year instead of every other year. Internally, the Utah CHIP Administrative office will be assessing CHIP health plans during FFY'06, including contract compliance and conducting direct provider relations.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

No focused quality studies have been conducted this reporting year. CHIP health plans maintain care coordination for special needs populations as part of their contracted services.

5. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

2005 Performance Report for Utah Commercial HMO's and Medicaid and CHIP Health Plans.

2003-2004 Utah Health Status Report, Table 4a

Table, Estimated Number and Percentage of Persons in Utah Who Lacked Health Insurance Coverage. 2001, 2003, 2004 Utah Health Status Surveys.

Additional Comments:

2005 Performance Report shows that CHIP health plans compare favorably to Medicaid plans on measures regarding children's access to primary care practitioners.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

   Every open enrollment period is analyzed to see what strategies are effective. Outreach is then designed based on feedback from the community, stakeholders, and CHIP Advisory Council. We continue to promote the Utah CHIP website, to allow online applications, and to promote a toll-free number which enrollees can call for information.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

   The Utah Department of Health measures effectiveness of outreach efforts by asking callers to the hotline how they heard about the program. TV commercials and news reports have consistently been the most effective outreach method. Other effective methods include mailings to community partners and friend and relative referrals.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

   The Utah Department of Health uses outreach to promote CHIP to eligible, but not enrolled, children statewide, and special efforts are made to reach out to Native American, Hispanic, and rural populations. Strategies like newspaper and radio ads have been used in the past. Recently CHIP retained an advertising agency that specializes in Hispanic outreach stategies. Based on their direction and evaluation results from past campaigns, we have added new strategies such as Spanish language TV ads to our campaign.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

   ☐ Yes
   ☒ No
   ☐ N/A

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

   ☐ Yes
   ☒ No
   ☐ N/A

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   When health insurance is available through a custodial parent's work and the cost of coverage is less than 5% of the household's countable gross income, the insurance is considered to be affordable and the children are not eligible to enroll in CHIP. In addition, Utah has a 90 day waiting period for applicants who have voluntarily terminated health insurance. Exceptions to the 90 day waiting period are for voluntary termination of COBRA and Utah Health Insurance Pool coverage, voluntary termination of coverage by a non-custodial parent, and voluntary termination of private health insurance purchased between CHIP open enrollment periods if the child met CHIP eligibility requirements at the time of purchase.

   The most recent analysis of CHIP crowd out was done in FFY 2000. The survey indicated that 10.4% of families applying for CHIP had never had insurance coverage, or were uninsured for an average length of 8.5 months previous to applying for CHIP.

4. At the time of application, what percent of applicants are found to have insurance?

   Based on denial reports from the eligibility computer system, during the open enrollment period held in FFY '05, 1,144 applications were denied (18.7% of all denials) because the family was currently enrolled in health insurance, or had access to affordable health insurance through their employment. This represented 11% of the total applications received during the open enrollment period.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

   Based on denial reports from the eligibility computer system, during the open enrollment period held in FFY '05, 58 applications were denied (less than 1% of all denials) because the family voluntarily terminated health insurance in the previous 90 days. This represented 1% of the total applications received during the open enrollment period.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   Utah CHIP's redetermination procedures are not the same as Medicaid. However, both Medicaid and CHIP send preprinted renewal forms to families the month immediately preceding the renewal month. Verification of income is required for Medicaid, but is only required for CHIP if the income on the renewal form has changed or the family is self-employed. Neither Medicaid nor CHIP requires a face-to-face interview.

2. Please explain the process that occurs when a child’s eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   Eligibility determinations for CHIP and Medicaid are done by the same eligibility staff. Either a CHIP application form or a Medicaid application form can be used to apply for either program. One challenge Utah has faced as a result of CHIP enrollment being limited to open enrollment periods, was that there were times when children would lose Medicaid coverage and could not be enrolled in the CHIP program. Utah has tried to address this challenge by changing policy to allow children to be enrolled in CHIP outside of an open enrollment period when they lose Medicaid coverage because they reach the maximum age for the Medicaid program they are enrolled in, or because they are no longer deprived of the support of one of their parents.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Both Medicaid and CHIP use the same computer system and staff to determine eligibility. However, there are differences in the provider networks. All services through CHIP are provided through two health maintenance organizations, Public Employees Health Plan (PEHP) and Molina Health Care, also a Medicaid Health Plan. All dental services for CHIP are provided through the Public Employees Dental Program.

   Medicaid services in the urban areas of the state are provided through three health plans, Molina Health Care, Healthy U, and Intermountain Health Care. In the rural areas of the state, Medicaid recipients receive services from any enrolled Medicaid provider.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?
  The month prior to the renewal month, a notice is sent along with a preprinted renewal form.
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  When a renewal is not completed, the disenrollment notice explains that the family may still complete the renewal by the end of the following month, and be re-enrolled without completing a new application.

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☐ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Two renewal processes are used, a mandatory renewal and a simplified renewal. A mandatory renewal requires the family to answer all questions on the form, sign it, and either send it to the eligibility case manager, or contact the case manager by telephone. A simplified renewal does not require the family to send in the form or take any further action unless any of the preprinted information on the form has changed.

☐ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

☐ Other, *please explain*:

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

   Preprinted renewal forms appear to be effective because they reduce the information the individual must complete, which saves them time. The mandatory and simplified renewal process is being reviewed to determine their effectiveness in simplifying the renewal process while still maintaining program integrity. Random edits will be conducted to analyze whether families understand what action is required, if children are being auto renewed who are no longer eligible, and if eligibility staff have followed the simplified process.

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

   ☐ Yes
   ☒ No
   ☐ N/A

   When was the monthly report or assessment last conducted?

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   No new studies have been conducted in FFY'05.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

   No

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

   NA

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

☐ Yes, please answer questions below.
☒ No, skip to Section IV.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan (Incidentally)
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☐ Parents and Caretaker Relatives
☐ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.)

4. What benefit package does the program use?

5. Does the program provide wrap-around coverage for benefits or cost sharing?

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured?

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned.

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

Enter any Narrative text below.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2005**	**2006**	**2007**
Insurance payments	33,882,244	47,686,340	46,544,455
Managed Care	0	0	0
per member/per month rate @ # of eligibles	0	0	0
Fee for Service	0	0	0
Total Benefit Costs	33,882,244	47,686,340	46,544,455
(Offsetting beneficiary cost sharing payments)	(700,000)	(868,801)	(762,159)
Net Benefit Costs	$ 33,182,244	$ 46,817,539	$ 45,782,296

Administration Costs			
Personnel	404,838	576,822	576,822
General Administration	154,658	220,359	220,359
Contractors/Brokers (e.g., enrollment contractors)	1,742,427	2,482,645	2,482,645
Claims Processing	0	0	0
Outreach/Marketing costs	154,527	220,173	220,173
Other na	0	0	0
Health Services Initiatives	0	0	0
Total Administration Costs	2,456,450	3,499,999	3,499,999
10% Administrative Cap (net benefit costs ÷ 9)	3,686,916	5,201,949	5,086,922

Federal Title XXI Share	28,689,149	40,017,538	38,982,295
State Share	6,949,545	10,300,000	10,300,000

TOTAL COSTS OF APPROVED SCHIP PLAN	35,638,694	50,317,538	49,282,295

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☐ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- ☒ Tobacco settlement
- ☐ Other (specify)

Enter any Narrative text below.

FFY'05 Managed Care Cost: $102.60 per member/per month rate @ 27,520 eligibles
FFY'06 Managed Care Cost: $111.70 per member/per month rate @ 35,544 eligibles
FFY'07 Managed Care Cost: $124.38 per member/per month rate @ 31,182 eligibles

An additional appropriation of $15,000,000 was budgeted for both FFY'06 and FFY'07 in order to increase enrollment. Of the additional appropriation, $14,000,000 was allocated to benefit costs with the balance of $1,000,000 being allocated to Administration Costs. The appropriation to Administration Costs will be used to hire additional eligibility workers needed to process the increased enrollment volume.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2005**	**2006**	**2007**	**2008**	**2009**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs					
Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)?

Please provide a description of any assumptions that are included in your calculations.

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   Since FY 2001, state funds come from the proceeds of the Master Settlement Agreement between the State and tobacco companies. In FFY 2004, the Utah State Legislature increased the CHIP funding from the Tobacco Settlement Account to allow for expansion of CHIP to cover more children and to restore dental services to the program. For FFY 2005, the Legislature again increased the funding from the Tobacco Settlement Account to allow CHIP to increase the number of children covered from a monthly average of 28,000 to 40,000 children.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   During FFY 2005 some changes in administration have occurred. In June, 2005, a new CHIP Bureau Director was hired and in September, 2005 a new actuarial specialist was hired. Although these changes have led to some transition, the CHIP program and administrative functions have not changed and the program continues to successfully cover the uninsured children in the state.

   Reported costs from one of the plans delivering CHIP services have risen dramatically. State financial staff are reviewing the costs to determine the accuracy of reported costs.

3. During the reporting period, what accomplishments have been achieved in your program?

   CHIP continues to build on the success of open enrollments. Each open enrollment focuses on delivering a clear, consistent message. These campaigns have motivated more and more families to apply and ultimately be enrolled in CHIP. The timing of each open enrollment period is coordinated as much as possible with the media in order to offer a new story each time and maximize the CHIP message. In January, 2005 a successful open enrollment period was held and CHIP was able to insure approximately 9,350 additional children. With the additional funding appropriated by the Utah State Legislature, CHIP was able to hold another open enrollment which is still in effect and an additional 7,600 children have been enrolled.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

   A bill is being sponsored in the upcoming Utah Legislature to increase the asset limits for Medicaid for children. If passed, the increased asset test would allow some children who are currently ineligible for Medicaid because of assets and enrolled in CHIP, to enroll in Medicaid. This would open CHIP slots that could be filled by other children.

   Utah CHIP is considering offering a premium assistance option that may be sought through a HIFA Demonstration.